North West **LHIN**

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3rd prize, North West LHIN Show Us Your Vision Photo Contest 2009

# Integrated Health Services Plan

2010-2013

Ontario
Local Health Integration Network

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# Chapter 1

## Introduction

This *Integrated Health Services Plan* (IHSP) is the second public presentation of the North West Local Health Integration Network's (LHIN) priorities and strategies, covering the three-year period beginning April 2010. This 2010-13 IHSP recognizes earlier planning work and focuses on further defining health care system needs and strategies to integrate the local health system.

**The IHSPs produced by LHINs across the province of Ontario are based on five common principles:**

- Community engagement;
- Coordination, cooperation and integration;
- Equity and diversity;
- Accountability and transparency; and
- Sustainability.

**The North West LHIN's strategic planning and resource allocation, and thus its IHSP, closely align with and support the provincial directions of the Ministry of Health and Long-Term Care (MOHLTC), including:**

- Improving access to emergency department care by reducing the amount of time that patients spend in the Emergency Department waiting;
- Improving access to hospital care by reducing the time spent designated as Alternate Level of Care patients in hospital beds;
- Improving access to integrated diabetes care by supporting the roll-out of the Diabetes Strategy;
- Improving eHealth Information and Communications Technology by supporting the eHealth Strategy; and
- Improving access to integrated mental health and addictions services by supporting the roll-out of the 10-year Mental Health and Addictions Strategy currently under development.

***Following extensive data collection (qualitative and quantitative), interpretation and analysis, and refinement through ongoing community engagement*, the following priorities for change will guide the activities of the North West LHIN in 2010-2013:**

***Access to and Integration of Services***

- *Emergency Department Wait Times & Alternate Level of Care;*
- *Primary Care;*
- *Specialty Care & Diagnostic Services;*
- *Chronic Disease Prevention & Management;*
- *Long-Term Care Services;*
- *Mental Health & Addictions Services;*

**People of Northwestern Ontario**

- Aboriginal Health Services;
- French Language Health Services;

**Enablers**

- Health Human Resources;
- eHealth; and
- Integration along the Continuum of Care.

**The plans outlined in this IHSP are presented with the overall goals of the Triple Aim Framework:**

1. Optimizing health (population health).
2. Optimizing care (patient satisfaction).
3. Optimizing resources (per capita cost).

In order to make the necessary health system changes to address priority areas and to implement the associated three-year plans, the North West LHIN will continue to partner with local health service providers and others with a focus on quality improvement, performance management, innovation, and integration. This work will advance the achievement of our vision ***Healthier people, a strong system–our future***.

# Chapter 2

# Summary of Provincial Strategic Plan and Alignment of IHSP

This *Integrated Health Services Plan* (IHSP) is a high level plan for improving health services over the next three years. It reflects the priorities of the Ministry of Health and Long-Term Care and is designed to promote equitable access to health care for all Ontarians. At the same time, the improvement strategies described in the following chapters reflect the local needs and strengths in the unique context of Northwestern Ontario.

The MOHLTC has identified three specific areas of focus. These areas are designed to improve access to care and include:

1. Reducing wait times in Emergency Departments.
2. Reducing the time patients spend as Alternate Level of Care in hospital beds.
3. Supporting the implementation of Ontario's Diabetes Strategy.

In addition, provincial strategies to improve mental health and addictions management and build innovative infrastructure through eHealth are priorities. Additional areas of provincial focus are anticipated with the forthcoming release of the MOHLTC's 10-year strategic plan.

## REDUCING WAIT TIMES IN EMERGENCY DEPARTMENTS

Ontarians expect quality care when visiting the Emergency Department (ED). Since reducing wait times in Emergency Departments can significantly improve the patient experience, it is one of the Ontario Government's top health care priorities.

Achieving shorter Emergency Department wait times involves change across the entire health system. For example, patients with non-urgent or less urgent needs account for about half of all Emergency Department visits.[1] Health service capacity is being built in communities so people have access to appropriate care outside Emergency Departments.

The North West LHIN is working with the MOHLTC to meet provincial targets for ED wait time reductions. To increase transparency, ED wait times are reported publicly.

## REDUCING TIME IN ALTERNATE LEVEL OF CARE (ALC) BEDS

When patients complete the acute care phase of their treatment in hospital, they may remain in acute care beds while they are waiting to be discharged or transferred. These patients require an "Alternate Level of Care" which is not available in the health care system.

Close to 19%[2] of patients currently in Ontario hospital beds are waiting for an Alternate Level of Care, such as a long-term care home bed, rehabilitation care bed or community health services. This may mean that a patient in the Emergency Department is not admitted, thereby causing a domino effect resulting in longer Emergency Department wait times.

The North West LHIN is working with the Ontario Government on a variety of initiatives that will help patients get the care they need – whether in a hospital, in a long-term care home or rehabilitation care facility, in the community, or in their own home.

## SUPPORTING THE ONTARIO DIABETES STRATEGY

The Ontario Diabetes Strategy is a multifaceted plan to improve outcomes for people with diabetes and to reduce the growing prevalence of this chronic disease. In 2008, about 900,000 Ontarians were living with diabetes (8.8% of the province's population).[3] The number of Ontarians with diabetes has increased by 69% over the last 10 years, and is projected to grow from 900,000 to 1.2 million by 2010. Treatment for diabetes and related conditions (including heart disease, stroke and kidney disease) currently costs Ontario over $5 billion each year. Rates of diabetes in the North West LHIN exceed the provincial average.

The Diabetes Strategy will improve access to prevention programs and team-based care. It includes an online registry that will give patients access to information and educational tools so they can better manage their disease. The registry will also enable health care providers to check patient records, access diagnostic information and send patient alerts. The registry will result in faster diagnosis, better treatment and improved management for Ontarians living with diabetes.

The North West LHIN is committed to improving access to diabetes care by supporting implementation of the provincial Diabetes Strategy.

## ENHANCING MENTAL HEALTH AND ADDICTIONS SERVICES

In addition to the three priorities described above, the Ontario Government has announced plans to enhance mental health and addictions services. About one in five Ontarians will experience a mental health or addiction problem[4] at some time, and the cost to individuals and society is significant.

The Minister's Advisory Group on Mental Health and Addictions is laying the foundation for a 10-year strategy to address this important issue. For the first time, the province's strategy includes mental health and addictions services funded by other Ontario ministries.

The LHINs will implement the provincial Mental Health and Addictions Strategy, helping to create a system that provides equitable access to safe, respectful and effective services.

## BUILDING ON AN eHEALTH FRAMEWORK

Ontario's eHealth Strategy supports the province's other strategies. By investing in information technology infrastructure, including the diabetes registry and electronic health records, patient care, safety and access will be improved. The LHINs will build on eHealth Strategy innovations to enhance system-wide integration and improve the health care system.

## A HEALTHIER ONTARIO

The Ontario Government's strategic directions helped to shape this *Integrated Health Services Plan*. Aligning local initiatives with provincial priorities will result in appropriate, coordinated, safe, and efficient health services.

MOHLTC »

**Information supporting the MOHLTC priorities is identified by this symbol throughout the IHSP.**

## Snapshot: Local Numbers Related to Provincial Priorities

### Emergency Department & Alternate Level of Care

- Non-urgent ED visits are the highest in the province (233 per 1000 population vs. 40/1000 provincially).[5,6]
- 9 out of 10 patients with complex conditions/requiring more time for treatment or hospital bed admission spend 14.8 hours in the Emergency Department.[7]
- 9 out of 10 patients with complex conditions/requiring more time for treatment prior to discharge from the ED spend 6.7 hours in the Emergency Department.[8]
- 9 out of 10 patients with minor or uncomplicated conditions/requiring less time for treatment or observation spend 4.1 hours in the Emergency Department.[9]
- Ten percent of the individuals who visit the Emergency Department are admitted to hospital.[10]
- Higher ED visits rates exist for all triage levels.[11]
- Percentage of Alternate Level of Care days is 5th highest in the province.[12]

### Mental Health and Addictions Services[13]

- 10% of Ontario's substance abuse and problem gambling clients reside in Northwestern Ontario (vs. 2% of the province's total population).
- Substance-related disorders account for the highest percentage (45.0%) of mental health visits to the emergency department (vs. 27.5% in the province).
- Mental health inpatients are more highly represented in substance-related disorders than provincially (37.6% vs. 15.1%).
- Due to a lack of specialized services in most communities, challenges with access to mental health services have been identified for clients in crisis and for those requiring specialized care, transitional care, supportive housing, and walk-in services.
- The population of new clients utilizing substance abuse and problem gambling services is older than provincial figures (30.5% under 35 years vs. 43.6% and 18.3% over 55 years vs. 9.9% provincially).
- The suicide rate is nearly double that of the provincial average (15.2/100, 000 vs. 7.7/100, 000).

### Diabetes

- High prevalence of diabetes (7.6% vs. 6.1% provincially for ages 12 and over).[14]
- Rates of diabetes in Aboriginal populations alone are estimated to be two to three times that of the general population.[15]
- High utilization of the Emergency Department (531/100,000 visits in the Northwest vs. 232/100,000 provincially).[16]
- Increased hospitalizations (236 separations vs. 103 in Ontario).[17]

### eHealth

- The comprehensive 2007-2012 *Northern Ontario eHealth Blueprint* provides a strong foundation for eHealth in the North West LHIN.[18, 19]
- The *Northern Ontario Information & Communication Technology (ICT) Planning Survey* (2008) identified that the North West LHIN had:
  - 17 eHealth projects ongoing or starting;
  - 15 organizations with formal project management capability;
  - 155 full time equivalent staff supporting ICT;
  - 37 organizations using telemedicine videoconferencing;
  - KO telemedicine providing services to 26 rural First Nations communities; and
  - 53 providers with their network upgraded by eHealth Ontario.

# Chapter 3

## LHIN's Vision for the Local Health Care System

The mission, vision, values and strategic directions developed by the North West LHIN Board of Directors provides direction and guides our activities.

### MISSION

Develop an innovative, sustainable and efficient health system in service to the health and wellness of the people of the North West LHIN.

### VISION

Healthier people, a strong health system – our future.

### VALUES

- Person-centred
- Culturally sensitive
- Sustainable
- Accountable
- Collaborative
- Innovative

### DRAFT STRATEGIC DIRECTIONS

In collaboration with our health system partners, the North West LHIN exists to achieve:

**Population Health:**

1. **Improved health outcomes resulting in healthier people**.
   - 1.1 There is a focus on provincial priorities
     - Through the ER / ALC Strategy, emergency wait times are reduced and people receive the right level of care.
     - Through the Provincial Mental Health and Addictions strategy, services will be evidenced-based, coordinated and provide opportunities for recovery.
     - Access to primary health care is enhanced to keep people healthy.
     - Through adoption and implementation of the eHealth Strategy, health information will be more accessible and coordinated enhancing safety, decision-making and patient satisfaction.
   - 1.2 Local priorities are identified and targeted through the North West LHIN's Integrated Health Services Plan (2010-2013).

**Patient Experience:**

2. **Continuous quality improvement.**
   - 2.1 Care delivery is centered on patient needs and experience.
   - 2.2 Evidence-based practices are identified and utilized widely.
   - 2.3 Patients transition seamlessly across levels of care.
3. **Access to health care that people need, as close to home as possible.**
   - 3.1 Wait times targets are met in Ministry of Health and Long-Term Care priority areas.
   - 3.2 The people of the Northwest are engaged in identifying and planning for their health needs.

**System Cost:**

4. **Well managed resources.**
   - 4.1 Value for dollars invested is achieved.

## CRITICAL SUCCESS FACTORS

1. **Integration and redesign of health systems:**

**System Design.**

1.1 Attributes of a high performance system are identified and incorporated.

1.2 System thinking and systematic analysis of processes underpin decision-making.

1.3 The right care is delivered at the right place, by the right provider, at the right time.

1.4 Opportunities for system integration are explored by the LHIN and health system partners.

1.5 Health service plans are well defined and focused on population needs.

1.6 Health system planning considers the impact of the broader determinants of health of our diverse populations.

1.7 eHealth is recognized as a key enabler of system integration.

1.8 The North West LHIN is highly qualified and effective in rural and remote health system development and support.

1.9 The Triple Aim Framework (population health, patient experience, system cost) underlies the work of the North West LHIN.

**System Voice.**

1.10 In consultation with our system partners, the North West LHIN is a key architect of health system redesign.

1.11 The North West LHIN contributes to more effective inter-sectoral collaboration.

1.12 The North West LHIN assists in shaping provincial policy.

1.13 The North West LHIN is recognized for effective leadership in achieving goals for the North West health system.

2. **A spirit of engagement and collaboration:**

2.1 Diversity is embraced and respected.

2.2 Engagement is fundamental to health system transformation.

- The North West LHIN is a leader in engagement strategies.

2.3 Effective communication by the North West LHIN is essential.

2.4 Collaboration is valued.

- The North West LHIN recognizes system partners who collaborate, innovate, and integrate.
- Partnerships exist based on trust, transparency, and system benefits.

3. **Learning, innovation, and research capacity:**

3.1 Learning is shared and leveraged across the system.

3.2 Development of health care leaders is nurtured.

3.3 New health system knowledge is acquired through research relationships with key partners.

3.4 Creative solutions are developed to improve the Northwest health system.

4. **Learning, innovation, and research capacity:**

4.1 Expectations are realistic and mutual.

- The stakeholders understand what the North West LHIN can influence and have reasonable expectations of the LHIN within its mandate and resources.
- Health Service Providers have a clear understanding of their responsibilities and accountabilities for results within the LHIN system.

4.2 Outcomes are evaluated.

- Outcomes assessment is considered integral to the system.
- Outcomes evaluation methods are further developed.
- Responsibility for health care transformation is understood and shared.

# Chapter 4

# Overview of the Current Local Health Care System

## 4.1 ROLE OF THE NORTH WEST LHIN

Mandated to plan, fund and integrate local health services, the North West LHIN does not directly provide health care services, but works with health service providers and community members to set priorities and plan health services in Northwestern Ontario. The North West LHIN allocates funding to the following health service providers:

- Hospitals (13);
- Community Care Access Centre (CCAC) (1);
- Community support service organizations (61);
- Long-term care homes (14);
- Community Health Centres (CHCs) (2); and
- Community mental health and addictions agencies (37).

The North West LHIN aims to improve the quality and accessibility of health care for all residents of Northwestern Ontario through better integration and coordination across the system.

## 4.2 GEOGRAPHY AND POPULATION CHARACTERISTICS

The large geography (see Figure 1) and relatively small, dispersed population of the North West LHIN results in challenges to health service delivery, including access to care, health human resources, the need for extensive travel, and higher costs of care per capita.

### LARGE GEOGRAPHIC AREA AND LOW POPULATION DENSITY

The North West LHIN has many small towns and First Nations communities located throughout rural and remote areas. Planning, delivering and accessing health services in these areas are often difficult due to the remote location of these communities. For example, many First Nations communities are accessible by air only. During much of the year, people in the Northwest are exposed to hazardous weather, poor road conditions and travel delays that make the long distance travel required to access health care services a significant challenge.

Figure 1. Map of the North West LHIN Area

### REGIONAL DEMOGRAPHICS

The North West LHIN has the lowest number of residents in the province and this population is decreasing while provincial numbers continue to increase.[20] Population by sub-area is outlined in Figure 2.

Figure 2. Total Population and Aboriginal Population by LHIN Sub-Area[21]

| North West LHIN Sub-Area | Total Population (2006 Census) | % Sub-Area Population Reporting Aboriginal Identity |
|---|---|---|
| Kenora District | 61,510 | 38.4% |
| Rainy River District | 21,565 | 21.7% |
| Thunder Bay District (excluding Thunder Bay City) | 26,155 | 19.9% |
| Thunder Bay City | 122,905 | 8.3% |
| **North West LHIN Total** | **232,135** | **19.0%*†** |

The proportion of the population age 65 and older in the North West LHIN is increasing as it is in the province overall. This trend is expected to continue (Figure 3) and in the Northwest it is partially due to the out-migration of those under 65 as a result of job loss.

Figure 3. North West LHIN Population Projection by Age Group[22]

| AGE | 2010 | 2030 | % Change |
|---|---|---|---|
| 0-19 | 55,125 | 45,318 | -17.8 |
| 20-44 | 71,892 | 64,387 | -10.4 |
| 45-64 | 69,557 | 53,299 | -23.4 |
| 65-74 | 17,628 | 32,018 | 81.6 |
| *65-69* | *9,845* | *16,690* | *69.5* |
| *70-74* | *7,783* | *15,328* | *96.9* |
| 75+ | 15,756 | 25,469 | 61.6 |
| *75-79* | *6,396* | *11,685* | *82.7* |
| *80-74* | *5,091* | *8,025* | *57.6* |
| *85-89* | *2,927* | *3,836* | *31.1* |
| *90+* | *1,342* | *1,923* | *43.3* |
| **All Ages** | **229,958** | **220,491** | **-4.1%** |

In the North West LHIN:

- Almost one-third (32.1%) of seniors live alone (vs. 25.7% provincially).[23]
- Slightly more than one in five people (age 15+) (21.8%) provide unpaid care or assistance to seniors vs. 18.7% provincially.[24]
- The Dependency Ratio (population age 0-19 and age 65+ divided by working age population) is 67.2/100 vs. 62.8/100 provincially [25]; the higher the ratio, the higher the burden on the labour force to support dependents. There appears to be a wide variation between sub-areas with the lowest ratio in Thunder Bay District (59.2) and highest in Rainy River District at 76.4.

Indicators of socioeconomic status show that the Northwest has many challenges. In addition to having the lowest rate of formal academic achievement, the North West LHIN has the highest unemployment rate in the province[26]—a trend that is expected to continue as resource-based industry declines across the region. It is known anecdotally that health status and utilization of health services is being impacted by widespread job loss in Northwestern Ontario; confirmation via traditional data sets will lag, given data collection cycles.

A high proportion of jobs in many communities in Northwestern Ontario have been focused in forestry and other resourced-based sectors. Rates of unemployment have increased dramatically in these areas, leading to decreased access to health benefits, reported increases in the number of people accessing mental health and addictions services, decreased socioeconomic status and decreases in population (including informal caregivers and health service providers).

* Kenora District sub-area excludes four Indian Reserve (IR) Census subdivisions in Kenora District that are part of the NE LHIN – Attawapiskat, Fort Albany (Part), Peawanuck and Marten Falls.

† Total North West LHIN estimate above adjusted for incompletely enumerated IRs is 19.2%.

Data collected during the *Share your Story, Shape your Care* project (Figure 4) and *Forestry and Health: An Exploratory Study of Health Status and Social Well-Being Changes in Northwestern Ontario Communities* (full reports for both in Supporting Documents) described the changes across the North West LHIN.

Figure 4. Effects of Economic Change Reported through *Share your Story, Shape your Care* (2009)

| Effect of Economic Change | Has affected "you or people in your region" (Yes, %) |
|---|---|
| Violence in the home | 67.3 |
| Divorce | 67.0 |
| Inability to fill prescriptions | 62.8 |
| Drug or alcohol abuse | 45.7 |
| Hard time affording healthy foods | 36.9 |
| Suffering from anxiety | 35.6 |
| More depression | 33.0 |

## LARGE ABORIGINAL POPULATION

The North West LHIN is home to one-third of the on-reserve Aboriginal population in Ontario, one-quarter of the off-reserve population, and just over half of all Indian Reserves and Indian Settlements.[27] The proportion of Aboriginal people in the North West LHIN is estimated to be 19.2% (after adjusting Census figures with Indian and Northern Affairs Canada (INAC) data for one incompletely enumerated Indian Reserve Census subdivision). This represents just over 44, 000 people self-identifying as Aboriginal. Of the 19.2% that identify as Aboriginal, 15.3% are North American Aboriginal and 3.4% are Métis). There is great variation between sub-areas in the North West LHIN with respect to the proportion of the population that identifies as Aboriginal; 38% of the Kenora area's population is Aboriginal compared to 8% for the City of Thunder Bay, still much higher than the provincial estimate of 2% (Figure 2).

It is recognized that the population count of Aboriginal peoples living in the Northwest region is likely an under-representation. While data describing health service utilization and health care outcomes for the Aboriginal residents of the North West LHIN are not available, there is some evidence that the Aboriginal population is especially vulnerable [28]; it has a high burden of illness, is often located in very remote communities and faces linguistic and cultural barriers to accessing health services. Poor health and social conditions result in earlier deaths among Aboriginal populations. This fact, along with a higher birth rate, results in a much younger Aboriginal population than the non-Aboriginal population. The development of chronic diseases earlier in life also has implications for health services requirements at younger ages than the non-Aboriginal population.

**Compared to the rest of Ontario, the North West LHIN has [29]:**

- **The largest geography (47% of the province);**
- **The lowest population (232,135 people with almost half living in the City of Thunder Bay);**
- **The highest unemployment rate in the province;**
- **A slightly higher proportion of people 65 years and older;**
- **The highest percentage of Aboriginal peoples; and**
- **A slightly lower proportion of Francophones.**

## HEALTH STATUS

The health of the population in the North West LHIN is generally more compromised than in other areas of the province. The aging and socioeconomic status coupled with the decline in the local economy result in a relatively heavy dependence on the health care system. Compared to the province as a whole, people in the Northwest make poor lifestyle choices and have less access to primary care. These factors contribute to the poor population health status in the North West LHIN.

**Relative to the rest of the province, the North West LHIN has a higher [30]:**

- Proportion who smoke (24.3% versus 18.7%);
- Proportion of heavy drinkers of those who drink (27.7 % versus 21.7%);
- Percentage who are overweight/obese population age 18 and older (56.0% versus 49.6%);
- Prevalence of participation and activity limitations (40.8% versus 33.1%);
- Rate of most chronic diseases including diabetes (7.3% versus 6.1%), high blood pressure (18.5% versus 16.4%) and arthritis (19.6% versus 16.9%);
- Rate of mortality per 100,000 (676 versus 559);
- Rate of potential years of life lost per 100,000 (6509 versus 4682);
- Percentage of deaths before the age of 65 (25% versus 21.5%);

**and a lower:**

- Percentage having contact with a medical doctor in past year (74.7% versus 80.6%);
- Life expectancy for females and males (80.5 years versus 82.7 years and 76.8 years versus 78.6 years respectively)[31]; and
- Proportion reporting self-rated health as "excellent" or "very good" (53.1% versus 60.0%).

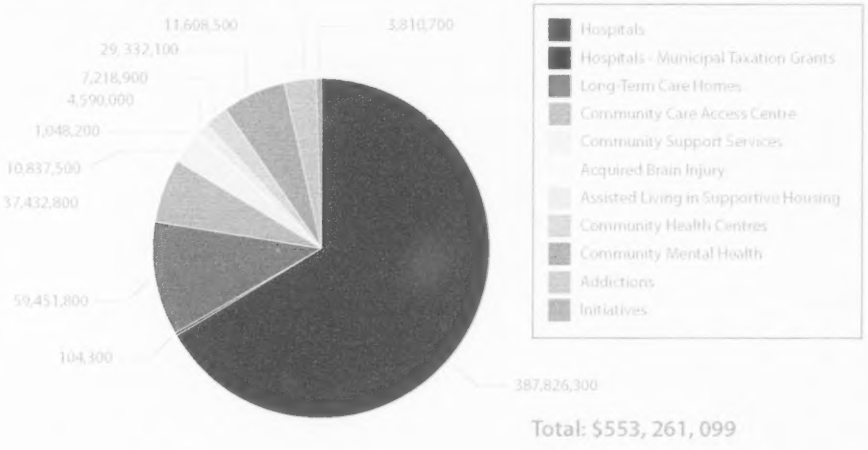
# 4.3 HEALTH SERVICES

Challenges in providing service across the Northwest can be expected to increase, given the:

- Declining overall population;
- Aging population;
- High and increasing numbers of unemployed;
- High burden of illness and chronic disease;
- Low socioeconomic status; and
- Poor health status.

Across the North West LHIN, health services are provided in a number of sectors. Although not all services are funded through the LHIN, Figure 5 below outlines the preliminary funding allocations, by sector area, through the North West LHIN for 2009/10.

Figure 5. Funding Allocations through the North West LHIN, by Sector, for 2009/10 (Ministry-LHIN Accountability Agreement) as of July 24, 2009



Addressing the challenges to providing access to quality care along the full continuum of care will require all partners (health service providers funded by the LHIN, other providers, sectors outside of health, and community members) to work together. Information about current service availability and utilization as of September 1, 2009 is outlined below, by sector.

## PRIMARY CARE

**In the North West LHIN, residents access primary care in the following locations (where available, numbers of services are provided in brackets):**

- Clinics (solo or group practice)
- Family Health Teams (12; call for proposals underway)
- Nurse Practitioner Clinics (1 to open in Thunder Bay 2010; call for proposals underway)
- Community Health Centres (2; NorWest CHC also operates 2 satellite offices and 1 mobile unit)
- Aboriginal Health Access Centres (3)
- Nursing Stations (24)
- Walk-In Clinics (available only in Thunder Bay)
- Emergency Departments (12)
- Nurse-Led Outreach Team for Long-Term Care (1; to be developed in Thunder Bay)
- Maternity Centre and Midwifery Clinic (both in Thunder Bay)

**Difficulty accessing primary care results in high rates of inpatient and emergency department care. Within the Northwest:**

- There are an estimated 13.4% (22,000) unattached patients age 16 and older[32] (the highest for all LHINs per capita).
- Residents report the lowest rates in the province for access to a medical doctor (84.5%) and consultation with a medical doctor (77.1%).[33]
- Only residents in the City of Thunder Bay receive more than 90% of their primary care physician services in their own sub-area.[34]
- Primary care providers may have to travel to remote communities and the travel time reduces their clinical hours.
- Practitioners in smaller communities are likely to take on different roles (e.g. ED coverage, Chief of Staff, anaesthesia), reducing the amount of time they are providing primary care services.
- Over 122,000 primary care visits are provided per year in remote First Nations nursing stations[35], funded by Health Canada.

> "Interprofessional practice expands access to primary care. This model works really well in the north."
> Dr. Joshua Tepper, September 2008, North West LHIN Videoconference Speaker Series

## COMMUNITY CARE

Care in the community is provided by the North West Community Care Access Centre (CCAC), community support service (CSS) agencies, MOHLTC, and/or through Health Canada. In the Northwest:

- The North West CCAC provides in-home and school health support services including case management, homemaking, nursing, and therapy.
- There are 61 Community Support Services provider agencies. Some of the services that are offered include meals delivery, social and congregate dining, transportation, friendly visiting, assisted living and supportive housing, and assistance for those living with acquired brain injuries.
- Thirty-five of the Community Support Service providers are Aboriginal organizations. Within those Aboriginal communities, the most common services offered are home maintenance and home help. These programs include activities that are delivered to elders, such as shoveling walkways, delivering lake water for drinking and cutting wood for heating. It should be noted that many First Nations communities receive funding for community support services through Health Canada.

- Homemaking and nursing services provided in First Nations communities are funded through the MOHLTC.
- It is recognized that a considerable amount of care in the community is provided by informal caregivers (i.e. family, friends, neighbours). Given the aging population in the Northwest and the decrease in population of those available to provide informal care, an increased need for formal health services is anticipated.

## ACUTE CARE

There are 12 hospitals providing acute care in the Northwest; Thunder Bay Regional Health Sciences Centre (TBRHSC) is the only tertiary centre. In the North West LHIN:

- Hospital utilization rates are the highest in the province (1202.4 inpatient discharges per 10,000 in 2007/08).[36]
- Non-urgent ED visits are the highest in the province (233 per 1000 population vs. 40/1000).[37, 38]
- Ten percent of the individuals who visit Emergency Departments (ED) are admitted to hospital.[39]
- Higher ED visit rates exist for all triage levels.[40]
- Reliance on the ED is largely a result of lack of access to primary care in the community (e.g. after hours or walk-in clinics).
- The percentage of Alternate Level of Care days is 5th highest in the province.[41]
- Approximately ten percent of patients are referred to other parts of the province and/or to Winnipeg, Manitoba for specialized services.[42]
- Critical Care Services are available in Dryden, Fort Frances, Kenora, and Thunder Bay.
- Care "Close to Home" is made possible through various regional programs coordinated with community hospitals (e.g. cancer care services, cardiac rehabilitation, mobile services, telemedicine services, and the Visiting Specialist Program).

## LONG-TERM CARE (LTC)

In the North West LHIN, there is a lack of community services outside of long-term care homes (e.g. supportive housing, respite, assisted living, home maintenance), creating a burden on the system and requiring individuals (seniors, people with a disability, people with a brain injury, etc.) to receive care in an appropriate location or setting, often far from home.

- There are currently 1,759 long-term care beds in the North West LHIN, including 117 ELDCAP beds funded through 7 hospitals and 1,642 long-term care beds funded through 14 long-term care homes. The 1,642 long-term care beds include 76 interim beds in 3 locations, 9 convalescent care beds in 1 location, and 10 short-stay beds in 4 locations.
- Older beds in five locations are eligible for redevelopment under the Ministry's Long-Term Care Renewal Strategy.[43]
- There are 300 beds in the City of Thunder Bay which will be redeveloped as part of the Centre of Excellence for Integrated Seniors' Services (CEISS), to be established in 2012. The CEISS project will include 336 long-term care beds of which up to 64 beds will be regional, behavioural beds; 132 new supportive housing units; enhanced community support services for 120 new clients; and increased CCAC services for 30 additional clients.
- Over the past year, occupancy of all Northwest long-term care home beds has ranged from a low of 98.0% (January 2009) to a high of 99.5% (July 2008) and typically averages 98.8%.[44]
- The Northwest has a slightly higher proportion of people 65 years or older compared to the province and the population under 65 is declining[45], creating concern that the care currently provided by informal caregivers will not be sustainable as the population ages.
- If current practice does not change, a 10% growth is projected in the demand for LTC home beds by 2015.
- The North West LHIN has the longest wait time to LTC placement of any LHIN (191 days) and is the third highest for patients on the LTC waitlist per capita.[46]

## COMPLEX CONTINUING CARE AND INPATIENT REHABILITATION

In the North West LHIN there are 270 complex continuing care (CCC) beds across the region and 50 rehabilitation beds at St. Joseph's Care Group in Thunder Bay. Twenty-seven percent (07/08) of all acute care ALC days in the Northwest were for patients who were eventually discharged to a CCC bed.[47]

## MOHLTC MENTAL HEALTH AND ADDICTIONS SERVICES

Thirty-seven community mental health and addictions agencies provide care through funding from the North West LHIN. A number of other services are provided through alternate funding arrangements (e.g. Health Canada, Ministry of Child and Youth Services).

There are two Schedule 1 facilities* (in Kenora and Thunder Bay) and one forensic unit in Thunder Bay Regional Health Sciences Centre. In the North West LHIN[48]:

- 10% of Ontario's substance abuse and problem gambling clients reside in Northwestern Ontario (vs. 2% of the province's total population).
- Substance-related disorders account for the highest percentage (45.0%) of mental health visits to the emergency department (vs. 27.5% in the province).
- Mental health inpatients are more highly represented in substance-related disorders than provincially (37.6% vs. 15.1%).
- More than half (56.1%) of clients requiring addictions services are unemployed or their employment status is unknown (vs. 35.3% in Ontario).
- Due to a lack of specialized services in most communities, challenges with access to mental health services have been identified for clients in crisis and for those requiring specialized care, transitional care, supportive housing, and walk-in services.
- The population of new clients utilizing substance abuse and problem gambling services is older than provincial figures (30.5% under 35 years vs. 43.6% and 18.3% over 55 years vs. 9.9% provincially).
- The suicide rate is nearly double that of the provincial average (15.2/100, 000 vs. 7.7/100, 000).

### A Strong Foundation: Building on the Strengths in Northwestern Ontario:

- **Technology:** Those living in the Northwest are leaders at using technology (including telemedicine and eHealth infrastructure (e.g. Picture Archiving and Communication Systems (PACS)) to improve access to care.
- **Partnerships:** People living in Northwestern Ontario have a history of working together to meet the needs of their community and improve the lives of their neighbours. This trend continues, as evidenced by the strong participation in community engagement activities.
- **Innovation:** The Northwest continues to be recognized for its innovation provincially, nationally and internationally. Planning for and providing care in remote and rural Northern communities results in the need to try new things to meet the needs of our region (e.g. service provision, health human resource planning and training).

Data collection, interpretation and analysis are ongoing and data is used to identify priorities, develop action plans and inform resource allocation and re-alignment. More extensive data for the North West LHIN is available in the Supporting Documents section.

*A health facility or hospital may request designation as a Schedule 1 psychiatric facility under the Mental Health Act.

- Unless specifically exempted by the Minister, a designated Schedule 1 psychiatric facility must provide a program that includes the five essential services listed in O.Reg.741 under the Mental Health Act. The essential services are:
  - In - patient services
  - Out - patient services
  - Emergency services
  - Day care services
  - Consultative and educational services to local agencies.
- A psychiatric facility may admit and detain involuntary patients under the Act, if it is required to provide in-patient services. The designated psychiatric facilities that may admit and detain involuntary patients are listed in Schedule 1 of the designations posted on the ministry's website. Designations and any exemptions from the essential services requirements in the regulation are made by the Minister.

# Chapter 5

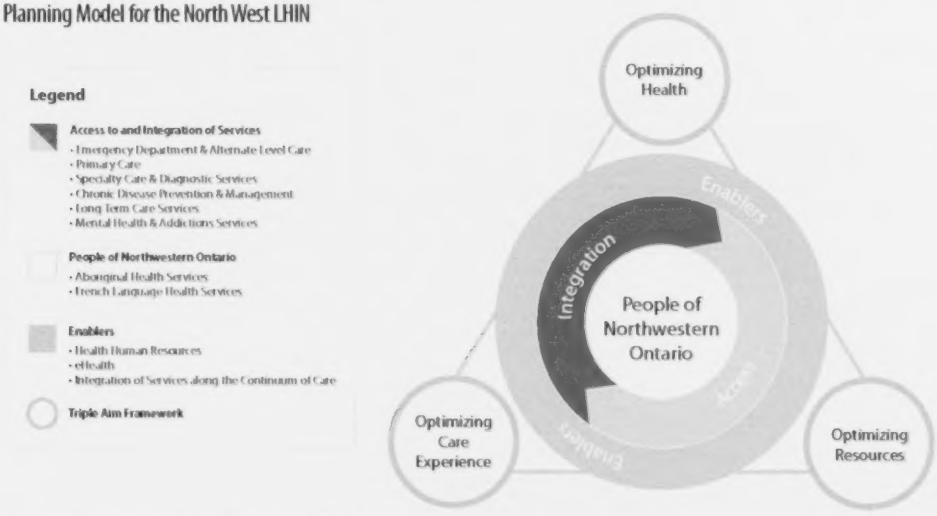
# Framework for Planning

To ensure that the North West LHIN is able to plan and integrate local health services and to allocate resources responsibly, long- and short-term planning is ongoing and supported through data analyses and community engagement. This supports our goal of making decisions that reflect the needs of people living in Northwestern Ontario. While there are many challenges to service delivery and system transformation in the Northwest, there are also many strengths and opportunities.

## 5.1 A PLANNING MODEL FOR THE NORTHWEST

The figure below illustrates a model for planning in the North West LHIN that incorporates the major issues identified through community engagement and data analysis (access to services, integration/coordination of services and enablers to supporting system change) and the Triple Aim Framework (section 5.2) for quality improvement, all focused to support the people of Northwestern Ontario in achieving and maintaining their health.

**Figure 6. Planning Model for the North West LHIN**




### 5.1.1 ACCESS TO AND INTEGRATION OF SERVICES

Access to and integration/coordination of services along the continuum of care in communities across the North West LHIN is a challenge. This is evidenced by the proportion of unattached patients, the high use of emergency services, the Alternate Level of Care pressures, and data obtained through community engagement.

Access includes having a primary care provider ('medical home') to support primary care needs and referrals between services, meeting eligibility requirements for some services, having available spaces, and receiving services in appropriate formats to allow all people in Northwestern Ontario to access care.

Transportation presents a barrier to accessing health services in many LHINs, but is of particular concern in the Northwest, where there is considerable distance between communities and a lack of transportation services (including taxis, buses, trains, flights, etc.) between and within most communities. Emergency transportation is often by air, as is travel from many of the remote First Nations communities. The issue of non-urgent transfers by land ambulance is a significant concern for providers and clients in Northwestern Ontario and the vast geography of the region results in a large number of these transfers. Given the importance transportation plays in accessing care, it will need to be addressed in all priority area implementation plans (Chapter 6) and through strong partnerships across many sectors and jurisdictions.

> "Integration is not about consolidating fragmentation."
>
> Dr. Charles Boelen, 2007, Meeting with North West and North East LHINs and Northern Ontario School of Medicine

Integration of services is a mandate of the LHINs. By addressing gaps and reducing duplications in service, more efficient use of available resources will result. Coordination and communication within and between services and sectors is integral to improving the quality of care, improving the patient/client experience and better utilizing scarce resources (including human resources, money and time).

### 5.1.2 PEOPLE OF NORTHWESTERN ONTARIO

The ultimate goal of the LHIN's work is to improve the health status and care experience for those living in Northwestern Ontario through planning, integration and best allocation of funding. The small population (232,135) of people who reside in the North West LHIN will all potentially require some type of health service based on their unique needs. In order to ensure client-centred planning, the North West LHIN must consider the needs of all residents, respecting language and cultural needs, including those with special needs and/or disabilities, those of all ages, and families and support systems.

Our goal is to ensure best provision of services for all residents of the Northwest and therefore services for Aboriginal and Francophone sub-populations are specifically reflected as priority areas.

### 5.1.3 ENABLERS

To address the needs of our region, enabling strategies will be required. eHealth is recognized by health service providers and the general public to be integral in supporting access to and integration of services, to improving quality of care and health outcomes and to supporting performance management. Without a supply of health human resources, care delivery would not be possible. It is imperative to use our workforce wisely, to its fullest scope of practice and to work with partners to meet the current and future demand for trained professionals. The integration of services along the continuum of care will enable the transformation required in our health system.

## 5.2 FRAMEWORK FOR IMPROVING QUALITY

To support quality improvement in LHIN activities and health system redesign, the North West LHIN is initiating use of the Institute for Healthcare Improvement's **Triple Aim Framework**[49] (see Figure 6).

The Triple Aim Framework proposes a set of aims in three areas (improving population health, individual care experience and per capita cost); system level metrics in all three areas; an integrator capable of bringing together needed care on behalf of a population; and a set of design concepts. These concepts include:

- Enhancing the role of patients and families in designing and managing care;
- Redefining the role of primary care, and actively addressing opportunities to prevent disease and promote health;
- Focusing intentionally on cost control by improving coordination across the continuum of care, reducing unwanted variation and reducing overuse of services; and
- Building capability to integrate health care, public health and social care on behalf of a population.

This model of quality improvement aligns with other rapid improvement cycle initiatives (e.g. PDSA—Plan, Do, Study, Act) that are being used by many health service providers in the Northwest. To support understanding and adoption of this framework, education sessions and ongoing communications across the region will occur.

## 5.3 SUPPORTS FOR PLANNING FRAMEWORK

To address the priorities of the North West LHIN, implementation of the planning framework presented will be supported through data support, partnerships, innovation, accountabilities, and fiscal enablers, as outlined below.

### 5.3.1 DATA SUPPORT

To ensure that planning and resource allocation decisions are based on the best available data, the North West LHIN's collection, analysis and reporting of qualitative and quantitative data is ongoing. Variation between communities requires collection and utilization of local data, including extensive community engagement.

### Quantitative Data

Quantitative data are collected from many sources, ranging from local health service records to national surveys. Appropriate interpretation of the information is essential to draw conclusions that accurately reflect our environment.

It is recognized that data in many areas is limited (e.g. Aboriginal population count and health status) and improving accuracy and collection of local data and/or partnering with other agencies and jurisdictions will be required. The LHIN will continue to analyze data for gaps in information and supplement with local quantitative and/or qualitative data, where possible.

For information on health status, health service utilization and other available quantitative data for Northwestern Ontario, please visit the Environmental Scan section included in Supporting Documents.

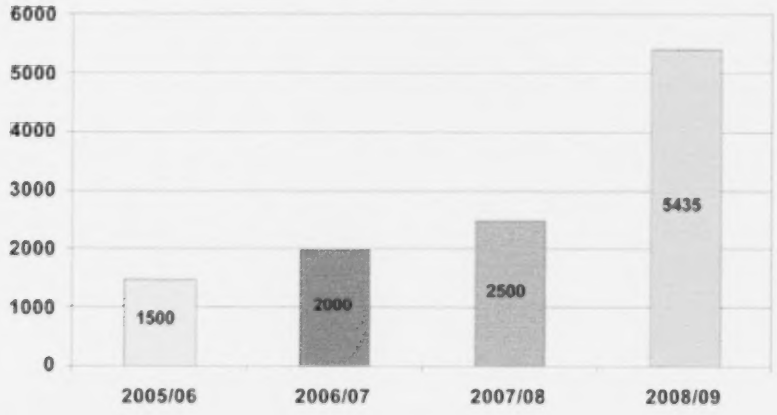
### Qualitative Data

Community engagement continues to be a priority for the North West LHIN, providing information that is used when identifying health system priorities, opportunities to develop new partnerships and innovations to overcome challenges.

***Share your Story, Shape your Care*** **was the LHIN's largest engagement activity in 2009. Over 800 people from across the Northwest identified priorities for health care, weighed in on suggested actions and shared their stories and ideas for improving coordination of the health system. Summary reports of this initiative are available in Supporting Documents.**

The rich information gathered through community engagement is of great value to the North West LHIN, as reflected by the increasing number of sessions hosted and people involved (See Figure 7). Data collected through discussions with local residents and health service providers supports decision-making based on local realities, needs and opportunities. For additional information, please visit the Community Engagement section of Supporting Documents.

Figure 7. Number of People Engaged in North West LHIN Activities (2005/06 to 2008/09)




Given the interconnectedness of our health system, stakeholders include health service providers; community members and leaders; educators; municipal, provincial and federal government officials; other ministries and jurisdictions; and other funding agencies.

**In 2008/09, the North West LHIN hosted 331 sessions (including forums, roundtable discussions, meetings, workshops, and training) for over 5,400 participants.**

### 5.3.2 PARTNERSHIPS

Real system change requires collaboration by organizations, communities and individuals across the LHIN, and beyond Northwestern Ontario. Working with all partners who play an integral role in health care, including those who are not funded directly by the LHIN (e.g. public health, physicians, municipalities, etc.), is imperative to meeting local needs. For a complete list of stakeholders, please see the *Community Engagement Strategy* in Supporting Documents.

To support planning initiatives and identify integration opportunities, the North West LHIN has initiated a number of Advisory Teams, Committees and Work Groups to advance each priority area identified in the IHSP.

"Transformation has to be a daily preoccupation for everybody who works in the health care system, from the home care aide to the neurosurgeon."

Steven Lewis, March 2008, An Opportunity for Real Change: Advancing Health System Transformation in the North West LHIN

### 5.3.3 INNOVATION

To ensure that education and capacity-building sessions are available throughout Northwestern Ontario, the North West LHIN has hosted a number of sessions, including a videoconference speaker series, a number of forums featuring internationally recognized thought leaders and education/training sessions specific to clinical practice, system planning and required reporting.

Videoconferencing and webcasting are used extensively to provide and collect information and wherever possible sessions are archived online for viewing post-session or for those joining from afar. Social networking media such as YouTube, Facebook, blogs, and discussion boards have also been used to communicate with stakeholders.

To collect and celebrate innovations by health service providers and communities, the North West LHIN hosted *Building Quality and Efficiency: Together We Can* in March 2009. During this forum, local innovations were collected and shared across the region. Online submission of additional health system innovations and successes is possible through the North West LHIN's website. Local providers will continue to be featured in issues of *LHINkages*, the North West LHIN's newsletter.

### 5.3.4 ACCOUNTABILITIES AND FISCAL ENABLERS

The North West LHIN will continue to make a concerted effort to initiate integration discussions with health service providers and their boards of directors. Inclusion of integration plans in the **service accountability agreements** provides the health service providers with an opportunity to outline relevant integration initiatives within and across sectors as per the *Local Health System Integration Act,* 2006. The North West LHIN will continue to include integration as an integral component of all calls for proposals with the goal of enhancing opportunities to identify what is possible across the system.

While **funding** health system transformation priority areas identified in Chapters 6, the range of fiscal impacts varies depending on the type of strategy and its context and includes:

- Using special initiative funding (e.g. Urgent Priorities or Aging at Home);
- Identifying potential savings, including in-year surpluses, that might be reallocated;
- Evaluating the impact of strategies as they become more fully developed; and
- Reallocating resources from areas of low marginal benefit to areas of higher marginal benefit.

When determining funding allocations based on calls for proposals or other submissions, a priority-setting/decision-making framework is used by the North West LHIN. This model is based on current best practice and was developed with input from local stakeholders and in collaboration with other LHINs, and researchers Dr. Jennifer Gibson (University of Toronto) and Dr. Craig Mitton (University of British Columbia). Additional information on the framework is available in Supporting Documents.

# Chapter 6

# Priorities and Strategic Directions for the Local Health System

Priorities for change for the North West LHIN's *Integrated Health Services Plan* (2010-2013) closely align with the MOHLTC's priorities (see Chapter 2) and have been identified through ongoing community engagement, data collection and data interpretation and analysis. Priority areas for the North West LHIN are:

- Emergency Department Wait Times & Alternate Level of Care
- Primary Care
- Specialty Care & Diagnostic Services
- Chronic Disease Prevention & Management
- Long-Term Care Services
- Mental Health & Addictions Services
- Aboriginal Health Services
- French Language Health Services
- Health Human Resources
- eHealth
- Integration of Services along the Continuum of Care

Some of the objectives for each of the priority areas identified are long-term and their full achievement will require more than three years. The specific strategies identified in this plan are intended to advance the objectives over the coming three years.

*Given the interconnectedness of the health system, it is recognized that implementation plans for the various priorities overlap. Effective system change requires the involvement of all partners. The following activities are integral to advancing LHIN priorities:*

1. **Optimizing Health**

- Improve communication and coordination within and between health care sectors.
- Integrate services to improve health outcomes.
- Allocate resources to address local needs.
- Promote adoption of current best practices.
- Initiate and implement quality improvement initiatives.
- Support local innovation.
- Promote excellence in northern, rural and remote clinical practice, education and research.
- Ensure that all individuals, including those who are traditionally marginalized, are considered.
- Partner with stakeholders outside of the health care system to ensure solutions that incorporate the social determinants of health.

2. **Optimizing Care**

- Integrate services to provide seamless care.
- Empower individuals to take an active role in their health.
- Value and respect diversity of individuals.
- Improve patient experience through innovation and quality improvement.
- Require patient satisfaction/input be utilized in service planning and delivery changes.

3. **Optimizing Costs**

- Integrate services to utilize resources most efficiently.
- Align resources to maximize effectiveness.
- Improve effectiveness and efficiency through best practices and quality improvement initiatives.
- Incent innovation through targeted allocation to make best use of available resources.
- Increase accountability through the application of performance management.

## 6.1 ACCESS TO AND INTEGRATION OF SERVICES

### MOHLTC » Priority 1: Emergency Department Wait Times & Alternate Level of Care

**GOAL: To improve health system performance and integrate care for the patient/client in the right setting, at the right time, by the right provider.**

OBJECTIVES:

1. Reduce unnecessary Emergency Department visits.
2. Reduce the time spent waiting in the Emergency Department.
3. Improve bed utilization and patient flow across the system.
4. Improve patient/family satisfaction with the care experience.

IMPLEMENTATION PLANS:

- Implement innovative community-based and non-emergency alternate settings for care (i.e. nurse-led outreach team for long-term care, chronic disease prevention and management strategies, mental health and addictions strategies).
- Implement the Emergency Department (ED) Performance Improvement Program at high volume hospital sites in the North West LHIN.
- Create transitional and permanent long-term care spaces in the community.
- Create long-term capacity for quality improvement within hospitals and the CCAC setting in the North West LHIN through the Flo Collaborative Spread Strategy.
- Advance the recommendations from the Regional ED Study.

### Priority 2: Primary Care

**GOAL: To increase access to primary health care through increased use of interprofessional teams with members working to their full scope of practice.**

OBJECTIVES:

1. Increase the percentage of the population with regular access to a primary health care provider or team of primary health care providers.
2. Improve integration between hospitals and primary care delivery in smaller communities.
3. MOHLTC » Reduce Emergency Department visits and avoidable admissions to hospital.
4. Improve timely access to primary care services (e.g. same day access initiatives).

IMPLEMENTATION PLANS:

| | 2010/11 | 2011/12 | 2012/13 |
|---|---|---|---|
| Identify and champion innovative strategies for health service providers (HSPs) to work at their full scope of practice. | | | |
| MOHLTC Promote primary care delivery through telemedicine. | | | |
| Champion interprofessional learning and practice. | | | |
| Work with primary care providers in group and solo practice to identify opportunities to improve access to primary care services. | | | |
| Promote implementation of new primary care initiatives (i.e. Health Care Connect program, Family Health Teams, nurse practitioner clinics, and nurse-led outreach team for long-term care). | | | |
| Collaborate with partners to expand access to primary care through outreach and mobile services. | | | |

# Priority 3: Specialty Care & Diagnostic Services

**GOAL: To enhance access to specialty care and diagnostic services.**

OBJECTIVES:

1. Reduce access barriers to specialty care and diagnostic services.
2. Reduce wait times for procedures included in the Wait Times Strategy (i.e. hip and knee replacement surgery, cataract surgery, cardiac surgery, cancer surgery, pediatric surgery, general surgery, and diagnostic services).
3. Improve system readiness for surge capacity in critical care due to pandemic or other event(s).

IMPLEMENTATION PLANS:

| | 2010/11 | 2011/12 | 2012/13 |
|---|---|---|---|
| MOHLTC Implement eHealth initiatives. | | | |
| Identify, monitor and report wait times for procedures included in the Wait Times Strategy. | | | |
| Implement models that improve access to specialty care closer to home including use of telemedicine, Visiting Specialist program and mobile services. | | | |
| Support application of clinical processes and pathways aimed at improving the flow of patients through the continuum of specialty care. | | | |
| Implement the North West LHIN Critical Care Surge Capacity Plan. | | | |

# Priority 4: Chronic Disease Prevention & Management

**GOAL: To improve chronic disease prevention and management through the creation of a culture of enhanced personal responsibility for health and the implementation of evidence-based practices.**

OBJECTIVES:

1. Reduce prevalence of chronic diseases through expansion of primary prevention initiatives.
2. Increase implementation of evidence-based practices in chronic care management (through programs such as the Quality Improvement & Innovation Partnership – QIIP).
3. Enhance self-management capacity amongst clinicians and the people in Northwestern Ontario.
4. MOHLTC Reduce Emergency Department visits and avoidable admissions to hospital.
5. MOHLTC Implement the Ontario Diabetes Strategy in the North West LHIN.

IMPLEMENTATION PLANS:




- Support initiatives to improve population health.
- MOHLTC Improve integration of chronic disease management services by implementing the electronic medical record, and working with providers to identify integration opportunities.
- Implement quality improvement initiatives leading to best practices such as QIIP and provider decision supports.
- Build self-management capacity through ongoing support of the regional network, continuing professional development and evaluation of the effectiveness of self-management programs.
- MOHLTC Implement initiatives aimed at achieving the goals of the Ontario Diabetes Strategy.

# Priority 5: Long-Term Care Services

**GOAL: To create an integrated system of services enabling the people of Northwestern Ontario to live with independence and dignity.**

OBJECTIVES:

1. Increase support available for people and their caregivers.
2. Improve access to long-term care services.
3. MOHLTC Reduce Emergency Department visits and avoidable admissions to hospital.

IMPLEMENTATION PLANS:

- Facilitate the development of the Centre of Excellence for Integrated Seniors' Services (CEISS) in the City of Thunder Bay, including:
  - Increased community support services;
  - Increased Community Care Access Centre services;
  - Enhanced supportive housing; and
  - Specialty services for clients with responsive behaviours.
- Promote quality improvement initiatives (e.g. falls prevention).
- Utilize findings from the Balance of Care research to advance plannings.
- Implement the Aging at Home Strategy.
- Collaborate to ensure the continued development of respite capacity that supports caregivers.
- Implement the nurse-led outreach team for long-term care.
- Improve access to supportive housing.




## MOHLTC » Priority 6: Mental Health & Addictions Services

**GOAL: To improve the quality of life for those affected by mental health and addictions issues.**

OBJECTIVES:

1. Improve access to mental health and addictions services and make the system easier to navigate.
2. Improve coordination of mental health and addictions services.
3. Improve outcomes for people receiving mental health and addictions services.
4. Implement the provincial 10-year Mental Health and Addictions Strategy.
5. MOHLTC » Reduce Emergency Department visits and avoidable admissions to hospital.

IMPLEMENTATION PLANS:

- Identify and implement opportunities for integration and realignment of mental health and addictions services to better meet client needs in the North West LHIN.
- Improve access to community-based mental health and addictions services.
- Improve access to specialized mental health and addictions services (e.g. telemedicine, Shared Care Model).
- Implement provincial initiatives (e.g. supportive housing for people with problematic substance use, stigma reduction).
- Support primary care providers to manage mental health and addictions care.
- Foster consumer survivor initiatives and peer support.
- Implement initiatives aimed at achieving the goals of the Mental Health and Addictions Strategy.

## 6.2 PEOPLE OF NORTHWESTERN ONTARIO

# Priority 7: Aboriginal Health Services

**GOAL: To work collaboratively with the Aboriginal community and the Federal and Provincial Governments in addressing issues of access to culturally sensitive and culturally appropriate health care programs and services.**

OBJECTIVES:

1. Establish mutually respectful relationships with the Aboriginal community.
2. Improve the delivery of services for Aboriginal peoples across the continuum of care.
3. Enable the Aboriginal community to have greater input into health planning that affects their communities.
4. Improve the cultural and linguistic accessibility of local and regional health services.
5. Support the Aboriginal community to effectively manage and report LHIN-funded programs and services.

| IMPLEMENTATION PLANS: | 2010/11 | 2011/12 | 2012/13 |
|---|---|---|---|
| Advance the work of the Aboriginal Health Services Advisory Committee. | | | |
| Engage with the Aboriginal community to identify local health needs and community priorities. | | | |
| Conduct an environmental scan regarding Aboriginal health services/programs and the health status of Aboriginal peoples in the Northwest. | | | |
| Leverage information sources in collaboration with other government departments and Aboriginal health service providers. | | | |
| MOHLTC » Actively involve Aboriginal communities and health service providers in local and provincial strategic planning processes. | | | |
| Create opportunities for stakeholders to share information and discuss issues and ideas for integration, future development and strategies to develop culturally appropriate programs/services. | | | |
| Promote cultural awareness and sensitivity with health service providers. | | | |
| Build capacity in the Aboriginal community for program/services management and reporting (e.g. Multi-Sectoral Service Accountability Agreement (MSAA)). | | | |

# Priority 8: French Language Health Services

**GOAL: To ensure that LHIN planning considers French language health services to improve access for the Francophone population.**

OBJECTIVES:

1. Support initiatives designed to attract and retain French speaking service providers.
2. Integrate French language health services in LHIN planning activities.

IMPLEMENTATION PLANS:

| | | 2010/11 | 2011/12 | 2012/13 |
|---|---|---|---|---|
| | Engage with the Francophone community to identify local health needs and priorities. | | | |
| | Promote awareness and sensitivity to French language health issues with providers. | | | |
| MOHLTC | Actively involve the Francophone community in local and provincial planning processes. | | | |
| MOHLTC | Support and implement provincial direction and strategies. | | | |

Photo courtesy of D. Horn, Thunder Bay
North West LHIN *Show Us Your Vision* Photo Contest, 2009

## 6.3 ENABLERS

# Priority 9: Health Human Resources

**GOAL: To make the best use of available health human resources and plan for future needs.**

OBJECTIVES:

1. Develop an understanding of current health human resource (HHR) requirements across the North West LHIN and in each sub-area.
2. Spread the work of HealthForceOntario.
3. Foster expanded implementation of interprofessional practice models, utilizing clinicians to their full scope.
4. Influence change leading to improved efficiency and effectiveness of clinical practice.

IMPLEMENTATION PLANS:

| | 2010/11 | 2011/12 | 2012/13 |
|---|---|---|---|
| · Develop strategies for health professionals to work to their full scope. | | | |
| · Link with academic health science partners to identify and address gaps, opportunities, skills and educational issues. | | | |
| · Collaborate with HealthForceOntario on: | | | |
| ED physician coverage; | | | |
| Regional Group Locum Program; | | | |
| Community Partnership Program; and | | | |
| Expanded implementation of interprofessional practice models. | | | |
| · Champion interprofessional and northern/remote learning and practice. | | | |
| · Identify HHR challenges, shortages and opportunities and work with health service providers in planning for the future. | | | |
| · Increase use of telemedicine to expand access to health service providers, particularly in rural and remote communities. | | | |

# MOHLTC » Priority 10: eHealth

**GOAL: To implement electronic health information and communication technology (eHealth ICT) in the North West LHIN.**

OBJECTIVES:

1. Increase eHealth ICT project implementation and adoption capability throughout the region.
2. Improve the value, timeliness and amount of decision support for health system decision makers.
3. Increase the accessibility to high quality eHealth ICT for health service providers.
4. Increase the understanding of eHealth ICT amongst the general public.
5. Improve patients' access to their health information and to health care management tools to support self-care.

IMPLEMENTATION PLANS:

| | 2010/11 | 2011/12 | 2012/13 |
|---|---|---|---|
| Utilize eHealth ICT solutions to enable improvement in clinical priorities such as chronic disease prevention and management. | | | |
| Expand the eHealth Project Management Office in the North West LHIN. | | | |
| Develop expert clinical panels to guide eHealth ICT efforts. | | | |
| Implement and expand the eHealth infrastructure in the North West LHIN. | | | |
| Assist in the expansion of telemedicine services. | | | |
| Implement eHealth technologies to support health service providers and consumers to achieve improved health outcomes. | | | |
| Implement initiatives aimed at advancing the goals of Ontario's eHealth Strategy. | | | |
| Accelerate electronic medical record (EMR) adoption and integration. | | | |

# Priority 11: Integration of Services along the Continuum of Care

**GOAL: To facilitate and enable integration of services across the health care continuum that optimizes health outcomes and improves system performance.**

OBJECTIVES:

1. Promote a culture of improvement, collaboration and accountability between health service providers for health system performance and outcomes.
2. Support integration activities that add value to the health system.
3. Increase and coordinate the utilization of technology that supports integration. MOHLTC
4. Improve client satisfaction with their care experience.
5. Reduce Emergency Department visits and avoidable admissions to hospital. MOHLTC

IMPLEMENTATION PLANS:

| | 2010/11 | 2011/12 | 2012/13 |
|---|---|---|---|
| Implement integration activities (formal/informal) that optimize services through cost and resource efficiencies. | | | |
| Identify integration opportunities and related enablers. | | | |
| Support evidence-based practice and innovative models of care that improve the quality and coordination of care. | | | |
| Integrate clinical processes between health care sectors where appropriate (e.g. eHealth solutions). MOHLTC | | | |
| Profile integration initiatives that improve service between health care providers. | | | |
| Develop an integration plan for the North West LHIN. | | | |
| Include integration as an integral component of calls for proposals. | | | |
| Encourage providers to streamline business/clinical processes (eliminate/reduce duplication) where possible within and between health care sectors. | | | |

# Chapter 7

# Rationale for Strategic Directions

Priorities and their related strategic directions (implementation plans) have been identified through extensive review and collection of available data and ongoing community engagement activities. Detailed reports for both quantitative and qualitative data are available in the Supporting Documents section.

## 7.1 DATA COLLECTION TO SUPPORT IDENTIFICATION OF PRIORITIES

### 7.1.1 QUANTITATIVE DATA

As mentioned in Chapter 5, data analysis is ongoing and includes review and interpretation of local, provincial and national data sets. Data collection and analysis continues throughout planning processes and priority-setting. Support for the priorities outlined in this *Integrated Health Services Plan* was provided by sector in Chapter 4 and is further supported by the information in this section.

### 7.1.2 QUALITATIVE DATA

The North West LHIN has engaged health service providers, community members and other partners extensively since the release of its 2007-2010 IHSP, building on the information that had already been collected and the relationships that had been formed. Implementation plans for identified priorities were discussed and refined with input from Advisory Team, Working Group and Committee members, health service providers and community members through in-person sessions, online and via videoconference/teleconference.

Although community engagement has been ongoing (with 12, 857 individuals involved to-date; 11, 157 since the release of the first IHSP), the largest single engagement initiative–*Share your Story, Shape your Care* was hosted in 2009. Over 800 individuals took part in this project, weighing in on priority areas and associated implementation plans and sharing their ideas and stories (good and bad experiences). Figure 8 outlines responses to the level of concern for priorities identified in the 2007-2010 IHSP.

**Figure 8. Level of Concern for Priorities Reported in *Share your Story, Shape your Care* (2009)**

| | Future Priorities (%) | | | | | |
|---|---|---|---|---|---|---|
| | Not Too Concerned 1 | 2 | 3 | 4 | Very Concerned 5 | I Don't Know |
| Access to Primary Care | 4.0 | 5.4 | 11.3 | 20.3 | 58.5 | 0.3 |
| Access to Specialty Care | 2.3 | 2.8 | 9.0 | 23.2 | 62.1 | 0.5 |
| Chronic Disease Prevention & Management | 4.5 | 8.6 | 19.7 | 27.2 | 38.3 | 1.7 |
| Long-Term Care | 3.1 | 3.7 | 11.1 | 25.4 | 55.8 | 0.9 |
| Access to Mental Health and Addictions Services | 6.5 | 7.9 | 16.7 | 27.9 | 40.0 | 1.1 |
| Integration of Services | 1.7 | 4.2 | 13.2 | 26.5 | 52.8 | 1.7 |
| Aboriginal Engagement | 12.9 | 11.7 | 22.6 | 23.3 | 25.7 | 3.9 |
| French Language Services | 26.6 | 19.3 | 25.7 | 15.9 | 8.3 | 4.2 |
| Integration of eHealth | 4.5 | 7.8 | 17.7 | 28.5 | 39.3 | 2.2 |
| Regional Health Human Resources Plan | 1.1 | 1.7 | 6.9 | 19.9 | 68.4 | 2.0 |

The priorities of greatest concern were Health Human Resources, Access to Specialty Care, Access to Primary Care, Long-Term Care, and Integration of Services.

Those participating in the *Share your Story, Shape your Care* initiative were also asked to identify what, if any, priorities (listed in Figure 9) they felt were missing from the 2007-2010 IHSP. Figure 9 identifies what additional priorities were suggested and in what priority area(s) of this IHSP the issues will be addressed.

Figure 9. Priorities Identified through *Share your Story, Shape your Care* as Missing in 2007-2010 IHSP and Where Included in 2010-2013 IHSP

| Additional Priorities Identified through Share your Story, Shape your Care | NW LHIN Priority Area | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Emergency Department Wait Times & ALC | Primary Care | Chronic Disease Prevention & Management | Specialty Care & Diagnostic Services | Mental Health & Addictions Services | Long-Term Care Services | Integration of Services along the Continuum of Care | Aboriginal Health Services | Ensuring French Language Services | eHealth | Health Human Resources |
| Prevention | X | X | X | | X | X | X | X | | | |
| Integration and Navigation | X | X | X | X | X | X | X | X | X | X | X |
| Home Care | X | | | | | X | | X | | | |
| Recruitment and Retention of Health Human Resources | | | | | | | | | | | X |
| Transportation | X | X | X | X | X | X | X | X | X | | |
| Education | X | X | X | X | X | X | X | X | X | X | X |
| Geriatrics and End-of-Life Care | X | | X | | X | X | X | X | X | | |
| Alternate Level of Care | X | X | X | | X | X | X | X | | X | |
| Wait Times | X | X | | X | | X | X | | | X | |
| Client Service and Support | X | X | X | X | X | X | X | X | X | X | X |

## 7.2 DATA SUPPORT FOR IDENTIFIED PRIORITIES

Data (quantitative and qualitative (community engagement quotes symbolized by )) for each identified North West LHIN priority are provided below. Data collection, interpretation and analysis will continue throughout the three years of the IHSP cycle and priorities and associated implementation plans will be updated as required.

### MOHLTC » EMERGENCY DEPARTMENT (ED) WAIT TIMES & ALTERNATE LEVEL OF CARE (ALC)

ED/ALC is a key priority for the Ministry of Health and Long-Term Care. Addressing this complex system challenge in the North West LHIN requires integration of various strategies and solutions that are shorter, medium and longer term. The goals are to provide Alternate Level of Care in the right setting, at the right time by the right provider; increase the coordination and integration of care across the health system; improve patient flow along the continuum; and build capacity in the system through innovative community-based and non-emergency alternative care settings.

In the North West LHIN, length of stay in the Emergency Department and Alternate Level of Care are concerns in larger communities, particularly in the City of Thunder Bay. In the Northwest:

- Non-urgent ED visits are the highest in the province (233 per 1000 population vs. 40/1000 provincially).[50, 51]
- 9 out of 10 patients with complex conditions/requiring more time for treatment or hospital bed admission spend 14.8 hours in the Emergency Department.[52]
- 9 out of 10 patients with complex conditions/requiring more time for treatment prior to discharge from the ED spend 6.7 hours in the Emergency Department.[53]
- 9 out of 10 patients with minor or uncomplicated conditions/requiring less time for treatment or observation spend 4.1 hours in the Emergency Department.[54]
- Ten percent of the individuals who visit the Emergency Department are admitted to hospital.[55]
- Higher ED visits rates exist for all triage levels.[56]
- Percentage of Alternate Level of Care days is 5th highest in the province.[57]

Lack of access to primary care and limited community services (e.g. supportive housing, assisted living, and support services such as homemaking, transportation, etc.) are system challenges that contribute to increased ED wait times and ALC days in the North West LHIN.

Addressing ED/ALC through the allocation of resources and implementation of action plans will be the focus for the priority areas outlined below.

*It is important to ensure that these community supports are in place so the hospitals/ER does not get backlogged!*

*It is definitely time to expand the supportive initiatives in our communities. Our acute care beds are overflowing with seniors who are unable to live in their home but have no supports in the community.*

## PRIMARY CARE

Primary care is provided in many settings across the North West LHIN, however access remains a substantial issue. The North West LHIN has the lowest rates of access to a doctor[58] and the highest proportion of unattached patients of all LHINs[59]. Models of care that improve access to a team of professionals (e.g. Community Health Centre, Family Health Team, Aboriginal Health Access Centre) increase access to and quality of care. Access is especially difficult after hours, where in each community (with the exception of some evening walk-in clinics in Thunder Bay) the only service available is through the emergency department. Poor access to a 'medical home' or regular primary care provider is evidenced by:

- The highest rate of non-urgent visits to the emergency department in the province[60,61] with higher rates at all triage levels.[62]
- Less people with diabetes able to get in to see a family physician, resulting in higher utilization of the emergency department (531/100,000 visits in the Northwest vs. 232/100,000 provincially) and increased hospitalizations (236 separations vs. 103 in Ontario).[63]

With the vital role primary care plays in the health system, improving access to services will result in better health outcomes, quality of care and integration along the continuum of care.

*Often you phone your doctor re: a health concern, and the soonest appointment you can set is 3 months away. You are then left going to emergency.*

*Maximizing the use of skill sets of current health care providers, including an awareness of upcoming changes to scope of practice, will improve access to primary care.*

## SPECIALTY CARE & DIAGNOSTIC SERVICES

In order to access specialty care, patients in rural areas must travel long distances to tertiary centres such as Thunder Bay, Winnipeg or beyond. While there are 71 specialist physicians/100, 000 population in the Northwest, there are only 5/100, 000 in the Rainy River District and 26/100, 000 in the Kenora District.[64] Specialty groups often cited in short supply include psychiatry, child and youth mental health programs, dermatology, dialysis, and cardiac care.

Procedures included in the provincial Wait Times Strategy (see Chapter 8) are monitored and reported on an ongoing basis, with opportunities for expanding capacity reviewed as required. Access to specialty care services is also made possible through the following in Northwestern Ontario:

- Visiting Specialist Program (633 clinic days in 2007/08; the most common being orthopaedics, neurology and dermatology).[65]
- Mobile diagnostic services (e.g. Ontario Breast Screening Program coach, telecopthamology, NorWest CHC Mobile Unit).

- Telemedicine (in 2008/09 18,501 events were hosted and 17,081 events attended via the Ontario Telemedicine Network and 2,563 events through KO Telemedicine).[66,67]
- The Northern Health Travel Grant program enabled many North West LHIN residents to access specialty care services in 2007—almost 47, 000 patient grants were provided, along with 4, 700 companion grants. The cost of these grants was close to $14 million.[68]
- Improved access to and integration of specialty care services (including diagnostics) is expected to result in improved outcomes for clients and higher client satisfaction.

*I recently had a referral to a specialist and there were mix ups with the referral not leaving the clinic, I waited patiently for a letter with an appointment. Not wanting to call busy offices and take up valuable time. Needless to say 6 months later I called to find out the referral had not left the clinic.*

*Telemedicine is amazing, for both education of families and professionals, as well as for consultations/assessments with professionals from larger cities.*

### CHRONIC DISEASE PREVENTION & MANAGEMENT (CDPM)

The health status of residents in the North West LHIN falls below that of the rest of the province on a number of measures. Currently the expected lifespan for both men and women in Northwestern Ontario is the lowest in the province[69] and rates of poor lifestyle choices (e.g. % smokers, % heavy drinks, % obese/overweight) are among the highest in Ontario.[70]

The North West LHIN has higher than provincial rates of chronic diseases including diabetes, high blood pressure and arthritis/rheumatism.[71] In Northwestern Ontario[72]:

- Overall mortality rates for diabetes, hypertension, chronic obstructive pulmonary disease (COPD), and arthritis are notably higher than provincial rates (the mortality rates for diabetes and arthritis are the highest among LHIN areas).
- Overall hospital separation rates for diabetes, hypertension, ischemic heart disease (IHD), stroke, COPD, asthma and arthritis are notably higher than provincial rates.
- North West LHIN residents had the highest rate of hospitalization for diabetes and stroke among LHIN areas.
- ED visit rates for diabetes, depression, hypertension, IHD, stroke, COPD, asthma and arthritis are notably higher than provincial rates (ED visit rates for North West LHIN residents were the highest among LHINs for diabetes, asthma and arthritis).

With incomplete data available for Aboriginal populations, the prevalence is likely greatly underestimated, since diabetes rates in Aboriginal populations alone are estimated to be two to three times that of the general population.[73] Given the high prevalence of diabetes, the North West LHIN was selected as an early participant in the Ontario Diabetes Strategy.

Opportunities to improve the current state of CDPM in the North West LHIN exist. Quality improvement initiatives such as the Quality Improvement & Innovation Partnership (QIIP)[74] have the potential to transform CDPM in primary care. Increased capacity for self-management results in enhanced individual responsibility for health and work in this area has been promising to-date. There is also an opportunity to greatly improve population health through primary prevention efforts.

> "People with chronic conditions self-manage 99% of the time. We need to support them to do this the best they can."
>
> Mike Hindmarsh, July 2009, North West LHIN Videoconference Speaker Series

*I am a diabetic and I feel my disease and I get lost in the shuffle of health care.*

*Type 2 diabetes is affecting people at very young ages. A 5-year old child was recently diagnosed, for example. This is especially noticeable amongst Aboriginal peoples.*

## LONG-TERM CARE (LTC) SERVICES

Access to the full range of long-term care services continues to be a priority in Northwestern Ontario. There is limited (and often non-existent) access to services to support those requiring longer term care outside of a long-term care home setting. With a growing number of seniors (population requiring the majority of these services) and a decreasing number of informal caregivers (family members) to provide care at home, this issue is expected to become even more substantial without major changes to the system.

The Northwest has 1,759 long-term care home beds in communities across the region. The wait time to LTC placement in North West LHIN is the highest in the province, at 191 days[75], and if current practice does not change, a 10% growth in the demand for LTC home beds is expected by 2015.

> "The situation is distorted when the elderly are defined as the problem. Rather the problem is best defined as those factors which have created the gulf between the needs of the people and the approaches to address these needs."
>
> Cohen, quoted by Dr. Ken LeClair, June 2009, North West LHIN Videoconference Speaker Series

In addition to the lack of availability of long-term care services (including supportive housing, assisted living, respite, home-making, home maintenance, etc.), the following challenges exist in the North West LHIN:

- Recruitment and retention of staff, due to wage parity issues with the acute care sector.
- Inability to achieve sufficient critical mass in smaller communities to make it feasible to establish LTC home beds. These communities typically rely on ELDCAP or Complex Continuing Care beds.
- Problems maintaining older LTC homes, until such time that new replacement beds are re-developed (this is particularly an issue in the City of Thunder Bay).
- Provision of services for residents with behavioural issues in LTC homes.

Improving access to integrated long-term care services will support people in Northwestern Ontario to live with independence and dignity.

*I want to be independent as long as possible. Homecare–even in small amounts–can fill in things that become difficult for persons caring for themselves.*

*Most Aboriginal communities don't have any or insufficient home care services for the elderly. I think that most would be more comfortable in their own homes or in their own communities with a strongly managed system which is similar for all seniors with supports to help them in their day to day lives.*

## MOHLTC » MENTAL HEALTH & ADDICTIONS SERVICES

Challenges accessing mental health and addictions services continue to be an issue in communities across the Northwest (e.g. medication management is often a challenge due to a shortage of physicians and pharmacists). More than half of those requiring addictions services are unemployed (and looking for work) or their employment status is unknown (a trend that is expected to continue, given recent and ongoing economic changes)[76]; lack of employment benefits represents another barrier to accessing services.

Clients often have to leave their communities to access specialized services. Outside of Thunder Bay and Kenora there are few specialized treatment centres, detoxification options, withdrawal management programs, or transitional supports. Access issues are especially problematic for psychogeriatric services, transitional or supportive housing and walk-in mental health services.

Substance-related disorders account for the highest percentage (45.0%) of mental health visits by North West LHIN patients to the emergency department vs. 27.5% in Ontario.[77] For inpatient hospitalizations, when comparing North West LHIN and provincial data, mental health inpatients are more highly represented in substance-related disorders at 37.6% and 15.1%, respectively.[78] Prescription drug abuse, addiction to opioids and Fetal Alcohol Spectrum Disorder (FASD) are issues that are affecting service delivery and are expected to further increase the need for mental health and addictions services over time.

Improving access to and coordination of mental health and addictions services will improve quality of life and care for those requiring service and decrease the exacerbation of conditions resulting in longer term medical needs and social problems.

*I wonder how many lives could be spared if there was timely intervention? I speak from experience as I am an alcoholic/addict.*

*Consumers complain that mental health and addictions services are numerous, disconnected, siloed and inaccessible.*

## ABORIGINAL HEALTH SERVICES

Census (2006) data indicates there are just over 44,000 Aboriginal peoples living in the region of the North West LHIN. This figure represents 19.2% of the total population of the region. This is the highest percentage of Aboriginal peoples compared to LHINs across the province, the second being 10% in the North East LHIN. Only 2% of Ontario's population is Aboriginal.[79]

The average annual rate of increase for the Aboriginal population across Canada is 1.8% which is projected to be more than double the rate for the total population of Canada at 0.7%.[80] Based on a list of comparable health status indicators, however, the health of Aboriginal peoples is well below that of the rest of Canadians.

Issues faced by Aboriginal peoples are multi-faceted and include such factors as poverty, unemployment, discrimination, marginalization, and cultural alienation, putting Aboriginal peoples at risk for ill health. Reports indicate that Aboriginal peoples have [81-87]:

- Higher unemployment rates;
- Lower educational attainment;
- Higher incidence of welfare dependence;
- Higher levels of family violence;
- Three times the preventable disability rate;
- Higher crime rates;
- Poorer health;
- Higher suicide rates;
- Higher incidence of Type II diabetes and its related complications;
- Higher rates of infectious disease such as tuberculosis and AIDS;
- Higher rates of respiratory diseases; and
- Heart disease and cancer.

Health is determined by the complex interactions of these factors. Important health gains can be achieved by focusing interventions on the health system as a whole and by coordinating and integrating services, addressing issues of access to culturally and linguistically appropriate services to meet the needs of individuals and communities.

*We cannot presume to inflict our culture/beliefs on Aboriginal peoples but we need to better educate ourselves on theirs; in areas where there is a population of Aboriginal patients we need access to in-house staff (on call if needed) who can work with the healthcare team as a liaison.*

*Cross-cultural training is a must. The Aboriginal culture is a unique and strong culture. Most barriers I have seen include language and the general misunderstanding of the culture.*

## FRENCH LANGUAGE HEALTH SERVICES

The proportion of Francophones in the North West LHIN has dropped slightly (between the 2001 and 2006 Census) to 3.5% with a range between sub-areas of 2% in Rainy River, 3% in each of Kenora District and Thunder Bay City, and 11% in Thunder Bay District.[88] With few health service providers who can provide services in French, this presents an access barrier to health services for the Francophone population in Northwestern Ontario.

*Every health agency should have a list of all French services offered in their community.*

*Telemedicine could also be used in offering services in French to communities without French health services providers.*

## HEALTH HUMAN RESOURCES (HHR)

Recruitment and retention of health service providers continues to be an issue in the North West LHIN. In July-September, 2009 there were 62 vacancies for general practitioner physicians, 58.5 vacancies for medical specialists and over 100 vacancies for allied health care professionals in Northwestern Ontario.[89]

The majority of post-secondary and continuing education is provided through Confederation College, Lakehead University and the Northern Ontario School of Medicine. Interprofessional education and care is a growing focus for each academic institution. An anticipated outcome of interprofessional education is the maximized use of available health human resources and improved care provision and patient satisfaction.

> "'Team' is the big success factor… they can reach out to more of the population, can offer more options, have improved chronic disease management and promote self-care."
>
> Eileen Patterson, 2008, Interprofessional Teams in Primary Care: An Opportunity to Improve Chronic Disease Prevention and Management in the North West LHIN

With a mandate for recruitment and retention of health human resources, HealthForceOntario (HFO) continues to provide direction in health human resource planning in Ontario. The North West LHIN supports the implementation of HFO initiatives across Northwestern Ontario and ensures that the HHR issues and realities of the North West LHIN are considered in strategic planning at the provincial level.

*All providers should be working to their full scope of practice.*

*Innovative models of care delivery need to be piloted and evaluated. Ongoing education for all health professionals needs to be a priority, interprofessional learning opportunities that can be delivered via telemedicine or e-learning approaches.*

## eHEALTH

Modern healthcare requires information technology. Health service providers must have full and accurate understanding of patients' health otherwise there is a risk of receiving care that is ineffective and unsafe. There are hundreds of studies which show that well designed Electronic Health Information and Communication Technologies (eHealth ICT) are important to making patients safer, improving quality and making healthcare more convenient and efficient. eHealth ICT offers the potential to lower health system costs at a time when Canada needs to stem escalating health care costs. Canada Health Infoway estimates the return on Canada's investment for the electronic health record (EHR) initiative is between $6 billion and $7 billion annually[90], once the entire system is implemented.

"It's time to move forward with an electronic medical record as the benefits and cost savings to the health systems are monumental."

Dr. Alejandro Jadad, June 2008, North West LHIN Videoconference Speaker Series

*I think this [eHealth] is one of the most important goals–increase efficiency, patient safety, and decrease cost in the long run.*

*Currently records are being "lost" in the mail or haven't been "returned". This is extremely difficult if you have travelled great distances to see a specialist who doesn't have your test results. An electronic transfer would lessen wait times and make access to services much quicker.*

*Electronic medical record is the way to go, but a waste of resources if each service, program or organization is using different programs/software.*

*e-referrals would be helpful... however it would be excellent to add on a feature where the primary-care provider is alerted whenever something happens with that patient's file. This keeps the primary-care provider in the loop when their patient is seeing a specialist or other care provider.*

## INTEGRATION OF SERVICES ALONG THE CONTINUUM OF CARE

The health care system generally works in silos by sector; lack of communication and coordination between and across sectors continues to create issues. In order to achieve the North West LHIN's vision – ***Healthier people, a strong health system – our future*** – it is necessary to make best use of available resources through integration along the full continuum of care. Integrated care delivery will allow for a well-coordinated, seamless system of care and will provide better quality of care to the people of Northwestern Ontario.

Working in partnership with health service providers and communities to evolve and re-configure the services available, promote the adoption of best practice and foster a culture of quality improvement will improve care provision and patient satisfaction.

*I know the system and had a tough time, so I can see why others 'fall through the gap'.*

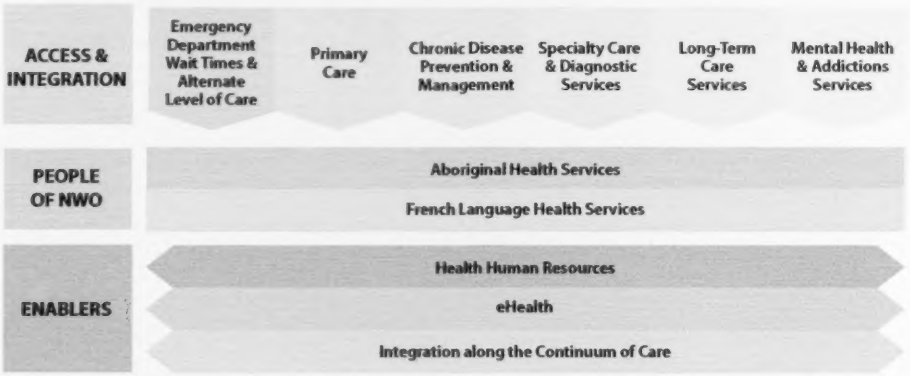
*A "one-stop" place like a website is great for those technologically able, but a community program with people who are able to sit down and outline all of the different programs is what's really needed. A confidential place to go where the information isn't just there, but where someone is there to look you in the eye and explain it to you is even better.*

## 7.3 INTEGRATED HEALTH SERVICES PLAN PRIORITIES— GUIDING SYSTEM TRANSFORMATION

The priorities outlined in this *Integrated Health Services Plan* will be addressed through the implementation plans identified in Chapter 6, ensuring relevancy/currency with updates being made as required.

The inter-relationship of the priority areas will require joint planning initiatives and system-level solutions as outlined in Figure 10.

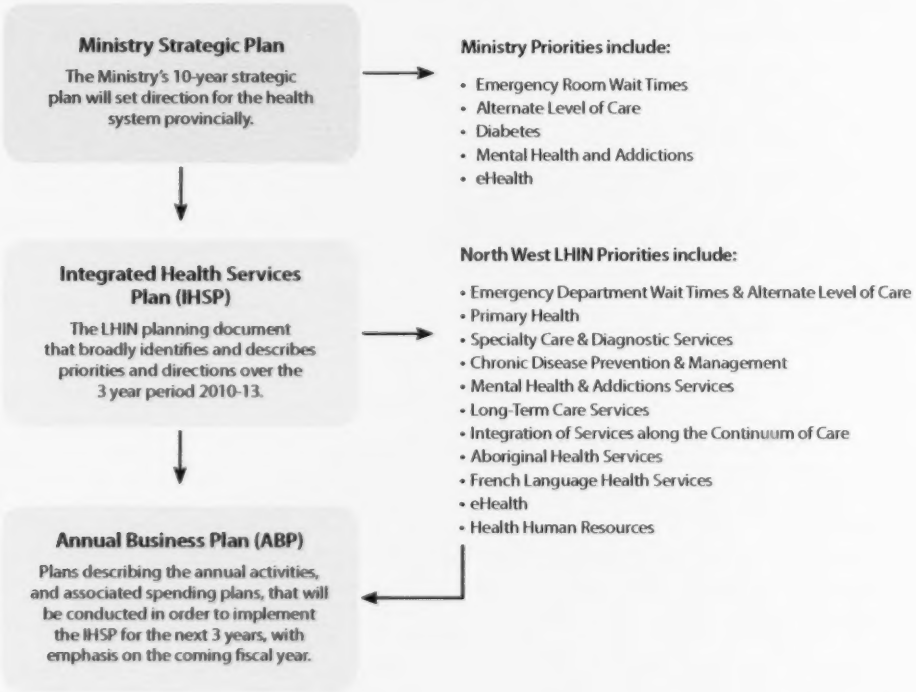
Figure 10. Planning Framework for the Identified IHSP Priority Areas




MOHLTC

The IHSP will continue to align with the Ministry of Health and Long-Term Care's strategic priority areas and is well-positioned to support any new directions. Implementation of the North West LHIN's IHSP will be monitored and reported on yearly through its Annual Business Plan. See Figure 11.

Figure 11. Relationship between MOHLTC Directions, IHSP Priorities and Annual Business Plan


Ministry Strategic Plan
The Ministry's 10-year strategic plan will set direction for the health system provincially.
Ministry Priorities include:
• Emergency Room Wait Times
• Alternate Level of Care
• Diabetes
• Mental Health and Addictions
• eHealth
Integrated Health Services Plan (IHSP)
The LHIN planning document that broadly identifies and describes priorities and directions over the 3 year period 2010-13.
North West LHIN Priorities include:
• Emergency Department Wait Times & Alternate Level of Care
• Primary Health
• Specialty Care & Diagnostic Services
• Chronic Disease Prevention & Management
• Mental Health & Addictions Services
• Long-Term Care Services
• Integration of Services along the Continuum of Care
• Aboriginal Health Services
• French Language Health Services
• eHealth
• Health Human Resources
Annual Business Plan (ABP)
Plans describing the annual activities, and associated spending plans, that will be conducted in order to implement the IHSP for the next 3 years, with emphasis on the coming fiscal year.

# Chapter 8

## How Success will be Demonstrated/Measured

Performance management is an integral part of quality improvement and system integration. As such, the North West LHIN continues to focus on indicator development and reporting to support local planning and provincial strategies.

The North West LHIN Board of Directors is accountable, through its Chair, to the Minister of Health and Long-Term Care for the LHIN's use of public funds and for its results in terms of goals and performance of the local health system.

The North West LHIN's Ministry-LHIN Accountability Agreement (MLAA) identifies specific performance targets related to the performance of the local health system which the LHIN monitors, works with health service providers to achieve and reports on a quarterly basis. Targets for health service providers funded by the LHIN are outlined in individual health service provider Service Accountability Agreements and are reported to the LHIN quarterly.

Figure 12 outlines the indicators and associated target ranges identified in the current MLAA. North West LHIN priority areas corresponding to these measures are identified. It is important to note that while these targets provide important information and fulfill requirements of agreements between the Ministry of Health and Long-Term Care, the LHIN and health service providers, there are other measures that will be used to support and guide plans to address the local priority issues outlined in Chapter 6. The North West LHIN will continue to support provincial initiatives, including targets resulting from MOHLTC strategies, as developed.

**Figure 12. North West LHIN Indicators and Targets Outlined in Ministry - LHIN Accountability Agreement**

| | | INDICATOR | LHIN BASELINE | LHIN TARGET RANGE 2008-09 | LHIN TARGET RANGE 2009-10 | PRIORITY |
|---|---|---|---|---|---|---|
| | TABLE A: ACCESS | 90th percentile wait times for cancer surgery | 46 Days | 45 Days | 45 Days | Specialty Care & Diagnostic Services |
| | | 90th percentile wait times for cardiac by-pass procedures | Not applicable | Not applicable | Not applicable | |
| | | 90th percentile wait times for cataract surgery | 413 Days | 182 Days | 130 Days | Specialty Care & Diagnostic Services |
| | | 90th percentile wait times for hip and knee replacement | Hip: 197 Days Knee: 251 Days | Hip: 197 Days Knee: 214 Days | Hip: 182 Days Knee: 182 Days | Specialty Care & Diagnostic Services |
| | | 90th percentile wait times for diagnostic (MRI/CT) scan | MRI: 77 Days CT: 84 Days | MRI: 28 Days CT: 28 Days | MRI: 28 Days CT: 28 Days | Specialty Care & Diagnostic Services |
| MOHLTC | | Proportion of admitted patients admitted within LOS target of ≤ to 8 hrs | 53% | Not applicable | 62% | Emergency Department Wait Times & Alternate Level of Care / Primary Care / Integration of Services along the Continuum of Care |
| MOHLTC | | Proportion of non-admitted high acuity patients treated within respective targets of: ≤ to 8 hrs for CTAS 1-2; ≤ to 6 hrs for CTAS 1-3; | 88% | Not applicable | 96% | Emergency Department Wait Times & Alternate Level of Care / Primary Care / Chronic Disease Prevention & Management / Mental Health & Addictions Services / Integration of Services along the Continuum of Care / Long-Term Care Services |
| MOHLTC | | Proportion of non-admitted low acuity patients treated within LOS target of ≤ to 4 hrs | 89% | Not applicable | 93% | Emergency Department Wait Times & Alternate Level of Care / Primary Care / Chronic Disease Prevention & Management / Mental Health & Addictions Services / Integration of Services along the Continuum of Care |
| MOHLTC | TABLE B: INTEGRATION | Percentage of alternate level of care (ALC) days | 11.4 | 14.78 | 13 | Emergency Department Wait Times & Alternate Level of Care / Access to Primary Care / Chronic Disease Prevention & Management / Mental Health & Addictions Services / Long-Term Care Services / Integration of Services along the Continuum of Care / eHealth |
| | | Median Wait Time to Long-Term Care Home Placement | 107 | 135 | 140 | Mental Health and Addictions Services / Long-Term Care Services / Integration of Services along the Continuum of Care / eHealth |

| TABLE A: ACCESS | TABLE B: INTEGRATION |
|---|---|
| • Objective: To improve access to appropriate levels of health care services for the local health system. | • Objective: To improve coordination and integration of health care among health service providers in the local health system. |
| • Expected Outcome: Patients/clients in the local health system will experience shorter wait times for access to the health care services identified above. | • Expected Outcome: More patients/clients in the local health system will receive health care in the most appropriate setting as determined by their needs. |
| • Other indicators are being considered as a measure of this expected outcome. | • Other indicators are being considered as a measure of this expected outcome. |

The North West LHIN will continue to work towards the targets identified above and to address the local and provincial priorities outlined in this IHSP. Ongoing indicator development, target setting, reporting, and analysis will be completed in partnership with local health service providers and the MOHLTC.

By continuing to work together in the directions provided, with time, we can achieve our vision – ***Healthier people, a strong health system – our future.***

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# Supporting Documents

**Community Engagement Reports and Resources**

i. Community Engagement Strategy

ii. Share your Story, Shape your Care project

  i. Summary Report
  ii Full Report
  iii. Storybook

iii. Aboriginal Health Forum, Pathways for Collaboration, Summary

iv. What Makes a Successful Interprofessional Team? Views from Health Service Providers in Northwestern Ontario

v. Health System Transformation in the Northwest: A Discussion with Physicians

vi. Diabetes Strategy Summary of Community Engagement

**Data reports**

i. Environmental Scan

ii. Population Health Profile

**Reports**

i. Rurality Literature Review

ii. Environmental Scan: Chronic Disease Prevention and Management for the North West LHIN

iii. Diabetes Management and Prevention: Environmental Scan for the North West LHIN

iv. Forestry and Health: An Exploratory Study of Health Status and Social Well-Being Changes in Northwestern Ontario Communities

v. Emergency Department Study

**Plans and Resources**

i. Aging at Home

  i. Directional Plan
  ii. Year 1 Service Plan

ii. Emergency Department/Alternate Level of Care

iii. eHealth Information and Communication Technology Blueprint—Tactical Plan

iv. eHealth Ontario Strategy (2009-2012)

v. Priority-Setting/Decision-Making Framework

**All documents are available at www.northwestlhin.on.ca under "Integrated Health Services Plan".**

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